

Key Components		Recommendation and Level of Evidence				
First, assess severity to decide initial therapy		Classification of Asthma Severity				
		<i>Intermittent</i>		<i>Persistent (Mild)</i>	<i>Persistent (Moderate)</i>	<i>Persistent (Severe)</i>
Components of Severity						
Impairment	Symptoms	≤ 2 days/week	> 2 days/week not daily	Daily	Throughout day	
	Nighttime awakenings	≤ 2x/month	3-4x/month	> 1x/week, not nightly	Often, 7x/week	
	Short-acting beta ₂ -agonist use for symptoms	≤ 2 days/week	> 2 days/week, not daily	Daily	Several times daily	
	Interference with normal activity	None	Minor limitation	Some limitation	Extremely limited	
	Lung function: FEV ₁ or peak flow FEV ₁ /FVC	Normal FEV ₁ between exacerbations > 80% > 85%	> 80% > 80%	60% - 80% 75% - 80%	< 60% < 75%	
Risk	Exacerbations requiring oral steroids	0-1/year	≥ 2/year			
	<ul style="list-style-type: none"> Consider severity & interval since last exacerbation. Frequency & severity may fluctuate over time for patient of any severity class. Relative annual risk of exacerbations may be related to FEV₁. 					
Recommended step for initiating treatment		Step 1	Step 2	Step 3		
		Re-evaluate control in 2-6 weeks and adjust therapy accordingly.				
On follow-up, assess control and step therapy up or down		Classification of Asthma Control				
		<i>Well-Controlled</i>		<i>Not Well-Controlled</i>	<i>Very Poorly Controlled</i>	
Impairment	Symptoms	≤ 2 days/week, but not > 1/day		> 2 days/week or many times on ≤ 2 days/week		
	Nighttime awakenings	≤ 1x/month		≥ 2x/month		
	Short-acting beta ₂ -agonist use for symptoms	≤ 2 days/week		> 2 days/week		
	Interference with normal activity	None		Some limitation		
	FEV ₁ or Peak Flow FEV ₁ /FVC	> 80% > 80%		60% - 80% 75% - 80%		
Risk	Exacerbations requiring oral steroids	0-1x/year		≥ 2x/year		
	Treatment-related adverse effects	Intensity of medication-related side effects does not correlate to specific levels of control, but should be considered in overall assessment of risk.				
Recommended action for treatment		<ul style="list-style-type: none"> Maintain current step Regular follow-up every 1-6 months Consider step down if well-controlled ≥ 3 months 		<ul style="list-style-type: none"> Step up at least 1 step Re-evaluate in 2-6 weeks 		
				<ul style="list-style-type: none"> Consider oral steroids Step up 1-2 steps Re-evaluate in 2 weeks 		
Step approach for asthma management (Use lowest treatment level required to maintain control.)		<ul style="list-style-type: none"> Quick relief medication for all patients: Inhaled short-acting beta₂-agonist (SABA) as needed for symptoms [A]. Intensity of treatment depends on severity of symptoms; up to 3 treatments at 20-minute intervals as needed. Short course of oral corticosteroids may be needed. Use of SABA > 2 days a week for symptom control (not prevention of exercise-induced bronchospasm) indicates inadequate control and the need to step up treatment. Patient education and environmental control at each step. Persistent asthma: Daily long-term control therapy [A]; consult with asthma specialist step 4 or higher [D]; consider consultation at step 3 [D] 				
		Intermittent Step 1	Mild Persistent Step 2	Moderate Persistent Step 3 Step 4		Severe Persistent Step 5 Step 6
Preferred Short-acting beta ₂ -agonist as required		Preferred Low-dose inhaled corticosteroid [A]	Preferred Low-dose inhaled corticosteroid + either a long-acting beta ₂ -agonist, a leukotriene receptor antagonist, or theophylline	Preferred Medium-dose inhaled corticosteroid + long-acting beta ₂ -agonist [B]	Preferred High-dose inhaled corticosteroid + long-acting beta ₂ -agonist [B]	Preferred High-dose inhaled corticosteroid + long-acting beta ₂ -agonist + oral corticosteroid [D]
Alternative Cromolyn or Leukotriene receptor antagonist; or Nedocromil; or Theophylline [B]		Alternative Medium-dose inhaled corticosteroid [B]	Alternative Medium-dose inhaled corticosteroid + either a leukotriene receptor antagonist or theophylline [B]	Alternative High-dose inhaled corticosteroid + either a leukotriene receptor antagonist or theophylline [B]	Alternative High-dose inhaled corticosteroid + oral corticosteroid + either a leukotriene receptor antagonist or theophylline [D]	

Warning for use of Long-acting beta-agonists (LABA). See Black Box Warning:

- Do not use LABA as monotherapy. Use only with an asthma controller such as inhaled corticosteroids (preferably combination product for children).
- Use for the shortest duration possible.
- Only use if not controlled on other drugs.
- Pediatric and adolescent patients who require the addition of a LABA to an inhaled corticosteroid should use a combination product containing both.

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline lists core management steps. It is based on the 2007 National Asthma Education and Prevention Program Expert Panel Report 3, Guidelines for the Diagnosis and Management of Asthma, National Heart, Lung and Blood Institute (www.nhlbi.nih.gov). Individual patient considerations and advances in medical science may supersede or modify these recommendations.